Welcome to our office

Today's Date ____________________

Patient Information

Last ____________________

First ____________________ MI ______

Street ____________________

City ____________________ State ______

Zip Code ____________________

Primary Phone (______) ____________________

Work Phone (______) ____________________

E-mail Address ____________________

Patient's SSN last 4 digits ____________________

Occupation (or Grade) ____________________

Employer (or School) ____________________

Spouse (or Parent's Name) ____________________

Spouse (or Parent's Work) ____________________

Patient's Date of Birth ____________________

Sex Male or Female

Insurance Information

Vision Insurance Plan ____________________

Subscriber Name ____________________

SSN last 4 digits or Member ID ____________________

Subscriber Date of Birth ____________________

Primary Medical Insurance ____________________

Subscriber Name ____________________

Member ID ____________________

Subscriber Date of Birth ____________________

Who is the responsible payor for this account?

____

Do you participate in a flex spending a account? O Yes O No

Our mission at Eye See Ravenswood is to provide the most comprehensive optometric treatment in a caring environment while offering state-of-the-art solutions for all of our patient's health and style needs.

Eye Health History

Date of last eye exam ____________________

By Whom? ____________________

What is the major purpose of this visit? ____________________

Are you having any problems with your current eyeglasses or contact lenses? Describe: ____________________

Are you interested in the latest advances in prescription lenses? O Yes O No

Do you think you might benefit from thinner lighter lenses? O Yes O No

How many pairs of prescription eyewear do you currently wear? ______

How many pairs of prescription sunwear do you currently wear? ______

Do you prefer not to wear your glasses at times? O Yes O No

Do you currently wear contact lenses? O Yes O No

What type? ____________________

Solutions used? ____________________

Are you having any problems with your current contact lenses? O Yes O No

Are you interested in the latest technology in contact lenses? O Yes O No

Have you experienced or been treated for any of the following?
(Please circle all that apply)

- Blurry Vision
- Headaches
- Crossed eye/Eye turn
- Floaters/Flashes
- Glaucoma
- Cataracts
- Macular Degeneration
- Retinal Detachment
- Iritis/Uveitis
- Eye Injury
- Corneal Abrasions
- Other ____________________
- Eye Infections
- Burning
- Itchiness
- Grittiness
- Tearing
- Dryness
- Double Vision
- "Lazy Eye"
- Light Sensitivity
- Glare/Halos

How many hours per week do you spend on the computer? ______

How many hours per week do you spend outdoors? ______

Participate in sports? Describe ____________________

____

Have hobbies? Describe ____________________

____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician ____________________

Phone ____________________

Date of Last Physical Check-up ____________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, Homeopathic remedies & birth control) ________

____

Do you have any allergies to medications? O Yes O No

If so, what medications? ____________________

____

Do you have any seasonal or environmental allergies?
What type? ____________________

Have you ever been diagnosed or treated for the following health problems?

Respiratory	O Yes	O No
Bronchitis	O Yes	O No
Ears/Nose/Throat	O Yes	O No
Sinus	O Yes	O No
Endocrine	O Yes	O No
Blood/Lymph	O Yes	O No
Thyroid	O Yes	O No
Fatigue	O Yes	O No
Fever	O Yes	O No
Blood Pressure High/Low	O Yes	O No
Diabetes	O Yes	O No
Kidney	O Yes	O No
Cholesterol	O Yes	O No
Digestive	O Yes	O No
Cancer	O Yes	O No
Integumentary/Skin	O Yes	O No
Muscle/Bone	O Yes	O No
Arthritis	O Yes	O No
Neurological	O Yes	O No
Psychological	O Yes	O No
Genitourinary	O Yes	O No
Hepatitis	O Yes	O No
HIV	O Yes	O No
Sexually Transmitted Diseases	O Yes	O No
Unusual Weight Loss/Gains	O Yes	O No
Other ____________________	O Yes	O No

Have you had any surgeries?	O Yes	O No
Do you use cigarettes/ tobacco products?	O Yes	O No
Do you use recreational drugs?	O Yes	O No
Do you consume alcohol?	O Yes	O No

Family Health History

Is there a family health history of any of the following?

		Relationship
High Blood Pressure	O	____________
Diabetes	O	____________
Elevated Cholesterol	O	____________
Heart Disease	O	____________
Cancer	O	____________
Blindness	O	____________
Color Blindness	O	____________
Cataracts	O	____________
Glaucoma	O	____________
Macular Degeneration	O	____________
"Lazy Eye"	O	____________
Other	O	____________

How did you choose our office?

- O Another Doctor/Healthcare Professional
- O Friend/Family Member
- O Insurance Listing
- O Outside Sign
- O Direct Mail
- O Print Ad
- O Yellow Pages: Which directory? ____________
- O Web Page: Which Website? ____________
- O Other: ____________

Who may we thank for referring you to our office?

____

Thank you for your trust in our office.

Andrea Stein O.D.
Eye See Ravenswood
4735 N. Damen
Chicago, IL
Ph: 773-961-8700
Fax: 773-961-8703